

EXHIBIT 164

UNISYS - P.O. BOX 7082
TALLAHASSEE, FL 32314-7082

PHARMACY IDENTIFICATION, ADDRESS, & PROVIDER NUMBER

109742300

STATE OF FLORIDA
REQUEST FOR PAYMENT
FLORIDA MEDICAID PROGRAM
PHARMACY CLAIM FORM

A - ADJUSTMENT V - VOID

TRANSACTION CONTROL NUMBER

RECIPIENT'S NAME (LAST, FIRST, MI)

MEDICAID I.D. NUMBER

5 DRUG GRANT
ADJUSTMENTOTHER PRESCRIPTION
INSURANCE?

REMARKS	80 RX NUMBER	100 MANUFACTURER	ITEM	PKG.	11A QUANTITY	12A DAYS SUPPLY	LINE NUMBER
	117780	00469	024925		110	1	0
	ME0036940	062597		R		500	
	117771	57317	0211006		1	1	1
	ME0036940	062597		R		9825	
							2
							3
							4
							5

18 PRINT OR TYPE UNUSUAL AND COMPOUND PRESCRIPTION INFORMATION BELOW WITH LINE NO.

19 TOTAL AMOUNT BILLED
10325

FORMER FOR RESUBMITTAL OF PREVIOUSLY DENIED CLAIM

IMPORTANT

READ CERTIFICATION STATEMENT ON THE REVERSE SIDE.
I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE
APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

FOR OFFICE USE ONLY

AUTHORIZED SIGNATURE / TITLE

BILLING DATE

7/14/97

061 7/94

0017906

VAC MDL 44051

VACMDL44051

P-00323

k

**State of Oklahoma
Oklahoma Health Care Authority
Prescription Drug Claim Form**

PLEASE PRINT CLEARLY

01 Provider Number (required)		02 Loc (req)		03 Billing NPI (optional)		04 Telephone Number	
05 Patient's Name Last First (required)		06 Member ID (Required)		07 Member's Date of Birth (Required mm/dd/yyyy)		08 Emergency (Y or N)	
						09 Pregnancy (Y or N)	
						10 NH/Pt (Y or N)	
11 Prescription Number (Required)		12 Date Prescribed (Required)		13 Date Dispensed (Required)		14 NDC Number (Required)	
						15 Quantity (required)	
						16 Days	
17 Brand Medically Necessary		18 Refill		19 Individual Prescriber's NPI Number (Required)		20 Individual Prescriber's Name Last First (Required)	
25 Provider's Name and Address				This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law.			
				I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.			
				26 Signature of Provider or Representative (Required)		27 Date Billed (Required)	
21 Charge (Required)		22 Third Party Paid		23 Total Amount Billed (Required)		24 Usual and Customary	

Mail Completed Claim Form to:

EDS

P.O. Box 18650

Oklahoma City, OK 73154

PHARM-1

DEY-SUB-OK-0000013

DEY-SUB-OK-0000013

Highly Confidential

Medicaid Provider Manual

APPENDICES	Section No(s) : Appendix 11R
MEDICAID CLAIM FORM INSTRUCTIONS	Trans. Bulletin:
Prescription Drug Claim - Form 204	Revision Date : July 1987
	Prev. Rev. Date: February 1976

HAWAII MEDICAL SERVICE ASSOCIATION, FISCAL ADMINISTRATOR
HAWAII STATE MEDICAID (Title XIX) PROGRAM
P.O. BOX 840, HONOLULU, HAWAII 96808
PRESCRIPTION DRUG CLAIM

FORM 204 (Rev. 10-87)

1 IDENTIFICATION NUMBER 5a		2 HNSA MEMBERSHIP NUMBER 5b 5c 5d 5e		3 PATIENT'S LAST NAME, FIRST NAME, MI 6		4 SEX 7		5 BIRTHDATE 8		9 DATES DISPENSED FROM MO DAY YR TO MO DAY YR	
10 SUBSCRIBER OR CASE NAME		11 PROVIDER OF SERVICE		12 ADDRESS (IF NOT IN THE STATE OF HAWAII)		13 CITY		14 STATE		15 ZIP CODE	
16 OTHER DRUG OR LIABILITY COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		17 DATE OF ACCIDENT MO DAY YR		18 IS THE ILLNESS OR INJURY: WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO		19 THIRD PARTY? <input type="checkbox"/> YES <input type="checkbox"/> NO		20 OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		21 AUTHORIZATION NO. 25	
22 IS PATIENT IN SHIP/ICF? <input type="checkbox"/> YES <input type="checkbox"/> NO		23 IS THERE A DIAGNOSIS? <input type="checkbox"/> YES <input type="checkbox"/> NO		24 IF YES, DIAGNOSIS		25 PRESCRIBED BY (LAST)		26 (FIRST)		27 (MI) PHYSICIAN NO.	
28 EX NUMBER		29 NAME STRENGTH OF DRUG		30 MANUFACTURER NO		31 PRODUCT NO		32 SIZE		33 MEDICAL NECESSITY	
34 EX NUMBER		35 NAME STRENGTH OF DRUG		36 MANUFACTURER NO		37 PRODUCT NO		38 SIZE		39 MEDICAL NECESSITY	
40 EX NUMBER		41 NAME STRENGTH OF DRUG		42 MANUFACTURER NO		43 PRODUCT NO		44 SIZE		45 MEDICAL NECESSITY	
46 EX NUMBER		47 NAME STRENGTH OF DRUG		48 MANUFACTURER NO		49 PRODUCT NO		50 SIZE		51 MEDICAL NECESSITY	
52 EX NUMBER		53 NAME STRENGTH OF DRUG		54 MANUFACTURER NO		55 PRODUCT NO		56 SIZE		57 MEDICAL NECESSITY	
58 EX NUMBER		59 NAME STRENGTH OF DRUG		60 MANUFACTURER NO		61 PRODUCT NO		62 SIZE		63 MEDICAL NECESSITY	
64 EX NUMBER		65 NAME STRENGTH OF DRUG		66 MANUFACTURER NO		67 PRODUCT NO		68 SIZE		69 MEDICAL NECESSITY	
70 EX NUMBER		71 NAME STRENGTH OF DRUG		72 MANUFACTURER NO		73 PRODUCT NO		74 SIZE		75 MEDICAL NECESSITY	
76 EX NUMBER		77 NAME STRENGTH OF DRUG		78 MANUFACTURER NO		79 PRODUCT NO		80 SIZE		81 MEDICAL NECESSITY	
82 EX NUMBER		83 NAME STRENGTH OF DRUG		84 MANUFACTURER NO		85 PRODUCT NO		86 SIZE		87 MEDICAL NECESSITY	
88 EX NUMBER		89 NAME STRENGTH OF DRUG		90 MANUFACTURER NO		91 PRODUCT NO		92 SIZE		93 MEDICAL NECESSITY	
94 EX NUMBER		95 NAME STRENGTH OF DRUG		96 MANUFACTURER NO		97 PRODUCT NO		98 SIZE		99 MEDICAL NECESSITY	
100 EX NUMBER		101 NAME STRENGTH OF DRUG		102 MANUFACTURER NO		103 PRODUCT NO		104 SIZE		105 MEDICAL NECESSITY	
106 EX NUMBER		107 NAME STRENGTH OF DRUG		108 MANUFACTURER NO		109 PRODUCT NO		110 SIZE		111 MEDICAL NECESSITY	
112 EX NUMBER		113 NAME STRENGTH OF DRUG		114 MANUFACTURER NO		115 PRODUCT NO		116 SIZE		117 MEDICAL NECESSITY	
118 EX NUMBER		119 NAME STRENGTH OF DRUG		120 MANUFACTURER NO		121 PRODUCT NO		122 SIZE		123 MEDICAL NECESSITY	
124 EX NUMBER		125 NAME STRENGTH OF DRUG		126 MANUFACTURER NO		127 PRODUCT NO		128 SIZE		129 MEDICAL NECESSITY	
130 EX NUMBER		131 NAME STRENGTH OF DRUG		132 MANUFACTURER NO		133 PRODUCT NO		134 SIZE		135 MEDICAL NECESSITY	
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706 EX NUMBER		707 NAME STRENGTH OF DRUG		708							